# LONDON BOROUGH OF TOWER HAMLETS

# COMMUNITY SAFETY PARTNERSHIP

# DOMESTIC HOMICIDE REVIEW

# EXECUTIVE SUMMARY

# MR AB AGED 79 YEARS

# KILLED IN TOWER HAMLETS

# IN AUGUST 2015

# REVIEW PANEL CHAIR AND AUTHOR

# BILL GRIFFITHS CBE BEM QPM

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## EXECUTIVE SUMMARY

This summary outlines the process taken by the London Borough of Tower Hamlets (LBTH) Domestic Violence Homicide Review (DVHR) Panel established in November 2015 under s9 Domestic Violence, Crime and Victims Act 2004, independently chaired by Bill Griffiths CBE BEM QPM, to review the death of Mr AB aged 79 in August 2015.

Mr AB was fatally stabbed by his youngest son, Mr YZ, who went on to attack family members respectively aged 11 and 2 years who were present at the family home. Mr YZ was subsequently diagnosed to be suffering from paranoid schizophrenia at the time. In September 2016, he was acquitted of all criminal charges. He was detained under a Restricted Hospital Order within the provisions of sections 37 and 41 Mental Health Act 1983.

The process began with a meeting in January 2016 of all agencies that potentially had contact with the family prior to the death of Mr AB. Agencies participating in the review are:

* Local General Practice Medical Centre, LBTH Clinical Commissioning Group (CCG)
* Metropolitan Police Service (MPS)
* Barts Health Trust who provide community services in Tower Hamlets
* East London Foundation Trust who provide mental health services in Tower Hamlets
* Victim Support
* LBTH Adult Social Care (ASC)
* LBTH Housing Options
* LBTH Positive Changes Services
* LBTH Domestic Violence Forum
* LBTH Domestic Violence and Hate Crime Team
* Independent Domestic Violence Advocate, Newham Asian Women’s Project
* A London Healthcare NHS Trust (latterly, and in the capacity of Mr YZ’s employers)

Agencies were asked to give chronological accounts of their contact with the victim and his son prior to his death. Each agency’s report covered a chronology of interaction with the victim and the perpetrator; what was done or agreed; and whether internal procedures were followed.

The accounts of involvement with Mr AB and his son cover different periods of time prior to Mr AB’s death. Some of the accounts have more significance than others. Of the above agencies, the local General Practice and the London Healthcare Trust provided a full Individual Management Review (IMR) that included conclusions and recommendations from the agency’s point of view.

Background

Mr AB was born in Bangladesh and was orphaned as a child. He migrated with his family to the UK in 1963 and found work labouring and in a timber factory until retirement. He is the father of seven children and Mr YZ is the youngest, aged 31 at the time of the fatal incident, and was living at home in Tower Hamlets. Mr AB was a devout Muslim who attended a local Mosque. He used prayers for socialising and was a popular attender at the Mosque. In retirement, his passion was tending his garden. He had been recently diagnosed with dementia, had been closely supported by his family and Mr YZ would accompany him at medical appointments.

Mr YZ had lived almost all his life in the family home. He left school aged 15 and, after a period at College, then ‘took some time out’. He found jobs in retail and also volunteered as a mentor in a charity for young people. He then worked for a London Healthcare NHS Trust in temporary positions via an agency between 2010 and 2014. He was regarded as a good worker and, when a substantive post became available, he applied and was appointed to a permanent position in administration based at one of the Trust Hospitals in January 2014. He told his family that he had found the job he wanted to do, despite it being quite a long daily commute to traverse Central London.

Following concerns about his work performance from about September 2014 and lengthy sickness absences due to stress at work, he eventually resigned in July 2015, three weeks before the fatal incident. The joint psychiatric diagnosis for the Court suggests very strongly that what was happening at work from Autumn 2014 is inextricably linked to his motivation for the attack, in fact, it is believed to be one of two factors that triggered his mental health problems, the other being the breakdowns of his first marriage in February and the second in July 2015.

There are four perspectives available that provide a window on what was happening in Mr YZ’s life in the period leading up to the fatal attack on his father:

1. The observations from family members
2. The records held by the local General Practice (he was seen by 7 of the 12 GPs)
3. His record of employment at the London Healthcare Trust 2014-2015
4. His own account provided in pre-trial interviews with two Consultant Forensic Psychiatrists (CFPs) on behalf of the Court. [Note: The clinical information and assessment from this source was not available at the time to health professionals working at the local General Practice and line managers and Occupational Health (OH) at the London Healthcare Trust]

## Timeline of events

From September 2005 to July 2007, Mr YZ reported to his GP that he was feeling paranoid that people were watching him, he felt worthless, hopeless and guilty and was suffering from panic attacks. He was prescribed medication and no further problems were recorded until 2014.

In September 2014, Mr YZ was married. A number of colleagues from work attended and he was keen that they sat together in a prominent position at the ceremony. The marriage did not work out and the couple had separated by February 2015.

Having started in the permanent position at a Trust Hospital in January 2014, Mr YZ’s work performance was assessed to have deteriorated from around June. He was subject to the Trust’s poor performance management policy and process, including provision of additional training, structured workflow and other support. At a performance review meeting with his first line manager in November, he asked to take leave the next morning to accompany his father to a medical appointment and was told to submit a leave request. This was not received at the Trust and a formal performance meeting was arranged for later in the month.

Mr YZ then reported sick with stress at work. He told his GP that he was being bullied at work by a new, second-line, manager, a disciplinary was pending, and he had taken out a grievance that this was racially motivated. He was prescribed anti-depressant medication. During December, Mr YZ sent a number of emails to managers about how he was feeling. His formal grievance was submitted in mid-December and a senior manager from another department appointed to investigate.

A phased return to work to another department was organised for February 2015. A replacement first line manager assessed that Mr YZ had: “Showed signs of aggression and anxiety towards returning, … Mr YZ would benefit from an urgentoccupational health assessment to support his return to work”. He was seen by an OH doctor who ascertained that Mr YZ was being supported and treated by his GP. The opinion was that: “He remained angry and bitter about his treatment … a phased return in March would be possible but he remained emotional and his issues with management would need to be resolved … he appreciated the support from his new line manager”. On receipt of the OH assessment, Mr YZ withdrew his grievance. He visited his GP in April and was fit to return to work in May. He did not visit the practice again until July.

In April, Mr YZ had found a new partner through a Muslim dating site and they were secretly married in July but separated after two weeks. The two families did meet once in this period.

A second phased return to work was arranged for May but Mr YZ later disclosed to the CFPs that he felt ignored by the second line manager whom he believed was bullying him through other people. The replacement first line manager assessed that Mr YZ showed signs of anxiety and a second urgent OH referral was made. Mr YZ was seen by a Consultant in Occupational Health in mid-June. Mr YZ said he remained under considerable stress due to perceived managerial problems and was assessed as suffering from: “Significant symptoms of anxiety and depression”.

The doctor called for a stress risk assessment and a case conference with the line manager. This did not happen because there was a delay when Mr YZ asked to see a draft of the assessment and then the doctor was involved in an accident. Mr YZ then asked that his grievance be progressed again. Planning for this commenced although the process was not completed.

During July, a call to the manager handling the grievance investigation seeking an update ended with Mr YZ in tears. He sent a text begging to be moved and then loitered near the manager’s office to make a personal plea. A move to another site was arranged for the following Monday. The day after he saw the senior manager about the move, the fire alarm sounded and Mr YZ emailed that an attempt had been made to burn down the hospital with him inside. This strange reaction was seen as part of his lobbying to be moved and the response was for him just to report to the new location. He told his family about his experience, but in a ‘jokey’ way so they were unconcerned. He then notified the manager that he was withdrawing his grievance and resigning. The manager gave him time to consider but Mr YZ resigned with effect from the end of July.

That day, in his first GP appointment since April, Mr YZ disclosed he had left his job due to bullying and was home all day thinking about what had happened. He was feeling work was against him and he had lost confidence. He was encouraged to resume the anti-depressant medication and to self-refer to psychology and other support available through the Practice.

Mr YZ later disclosed to the CFPs that in the two weeks prior to the homicide, he spent most of his time in bed. Noise from building works nearby affected his sleep. He was scared to go out at night because he thought the manager, whom he thought was responsible for the fire alarm incident, had people working for him who were spying on him. He had racing thoughts of danger going through his head.

On the day of the fatal incident in August, Mr YZ spent the day with his family. In the afternoon, he noticed a toy snake that had been left in a child’s sandpit in the garden. This made him think that he and his family were going to be tortured and killed, having not had that thought before. He went upstairs to his father first because he was the most vulnerable one and stabbed him through the chest. He then went after the children (Child B and Child C) because they were also vulnerable. Had he not been stopped by his sister (Sibling 5) and Child A, he intended to carry on killing his family members and then to kill himself.

## Key issues arising from the review

Mr YZ’s family had noted his depression and uncharacteristic loss of interest in socialising and knew this was related to problems with the job that he loved and the breakdown of his first marriage. The family simply provided loving support throughout this period and there was no reason for them to consider the state of his mental health.

From the General Practice perspective, they were working with what Mr YZ told GPs about his situation, with no collateral information from the NHS occupational health service that may have enabled a comparison of accounts. From September 2014, he had frequent GP appointments

and the IMR concluded that the symptoms observed were more consistent with that of a personality disorder or anxiety and it was unlikely that he was schizophrenic or schizoaffective when he was seen. Mr YZ did not attend the practice between April and July 2015.

The reflection from the Healthcare Trust is that Mr YZ’s time as an employee was not straightforward. There were issues related to both his ability to perform his duties and his conduct. His managers had no choice but to address these, which they did in line with the organisation’s poor performance and disciplinary polices. This was clearly difficult for him as evidenced both by a lengthy period of sick leave and the grievance process he initiated.

In his dealings with OH, his stress and anxiety related to the alleged bullying, harassment and discrimination is clearly documented. The allegations of bullying, harassment and discrimination were never investigated because he was either on sickness absence or had withdrawn the grievance and the allegations are not proven one way or the other. However, the impact that this perception had on his health was clear.

The aim of the poor performance management process is to improve performance, which it often does, but in this case, it did not. The use of the disciplinary policy, to deal with some clear behavioural issues, also seems appropriate but when added to the already initiated poor performance policy may have added to Mr YZ’s sense of feeling bullied. Delays in dealing both with the disciplinary issues and the grievance were driven primarily by his long period of sickness. and would have likely added to his anxiety.

His line managers were clearly concerned about his health and wellbeing and contacted him before both his planned returns from sickness. Appropriate referrals were made to the trust occupational health service to review his health and fitness to return to work. The advice following both reviews was that he was fit to return and ensured that the recommended arrangements, for a phased return with reduced duties and responsibilities, were implemented. He was appropriately referred to the Trust counselling service.

The recommendation for a case conference between OH and the line manager did not take place because the doctor was unavailable due to an accident and the recommended stress risk assessment was not undertaken. The senior manager dealing with the second grievance investigation had arranged for a move to another hospital site, but this did not happen because Mr YZ tendered his resignation.

The Panel have identified and listed potential connections between the two agencies (six on the part of the General Practice; eleven for the Healthcare Trust) with missed opportunities for the exercise of ‘professional curiosity’. The strong caveat on this aspect of analysis is that these connections and opportunities are identified through hindsight. Nonetheless, while the relationship between discreet events could be seen as only tenuous, the holistic perspective suggests more could have been done to exercise ‘professional curiosity’ and identify the underpinning causes of Mr YZ’s very evident distress with the situation at work

## Conclusions and lessons learned from the review

There is no history or trail of domestic abuse of any kind between Mr YZ and his father Mr AB whom he killed and the young relatives whom he seriously assaulted at their family home. This was a sudden and unexpected intra-familial homicide and assault committed by a young man who, undiscovered by anyone at the time, was suffering from paranoid schizophrenia.

Scrutiny of the General Practice notes in respect of Mr YZ show that schizophrenia was considered and excluded, though not all notes, and notably the last GP consultation did not make mention of thought disorder or hearing voices while mentioning paranoia. The impression at the time was of rumination rather than psychosis but there is no evidence that a full mental state examination was considered.

The Healthcare Trust point out that the Occupational Health’s function revolves primarily around determining fitness for work of the trust employees, both at the time of recruitment and when staff have extended periods of sickness.  They do not provide a primary care function and would not be involved in the *treatment* of acute or chronic illness of staff.  Whilst it would not always be necessary to have an information exchange between OH and the GP, it would have potentially been helpful in this case

The only possibility for a different outcome lay with the two sets of health professionals who were separately handling the indicators of YZ’s deteriorating mental health that, latterly, included strange behaviours such as his reaction to the fire alarm. Nobody had the whole picture because there was no sharing of patient information and symptoms between Mr YZ’s General Practice and the OH Doctors at the Healthcare Trust who twice interviewed him as an employee with long-term sickness absence and complaining of bullying, harassment and discrimination.

The line managers and HR professionals involved from the Healthcare Trust also had a duty of care to their staff member and there is evidence of concern for the impact on Mr YZ of the performance review and the disciplinary and grievance procedures that ran from October 2014 to July 2015, together with two sets of measures to support him with a phased return to full duties. It is also apparent that he was viewed as a problematic employee. The second OH assessment in June did not trigger the stress risk assessment and case conference (due to the unavailability of the OH doctor) that could have identified Mr YZ’s underlying mental health problems. This was quite close in time to his last GP visit in July when a full mental health assessment also could have been considered.

Thus, it is feasible that Mr YZ could have been treated earlier for his paranoid schizophrenia had either source of observation been aware of the other perspective. It is not suggested that any professional or agency failed to follow extant policy or protocol or is in any way to blame for what happened. As intended by the legislation, lessons to be learned have been identified by each agency

## Recommendations

Internal learning identified from the General Practice IMR is to consider using words like ‘paranoid’ only in the paranoid delusional sense and remember to record suicidality if the patient is depressed. Record presence/absence of thought disorder and hallucinations if recording paranoid ideation and review taking a forensic history. This recommendation has been implemented by the Practice. A second recommendation formed the basis for the Panel recommendation below.

Internal learning from the Healthcare Trust IMR questions whether delays in the OH service appear to have been related to the limited resources available to manage cases promptly. The Trust commissioned a strategic review of OH services which has recently been completed (November 2017). The Trust needs to consider the implementation of recommendations from this report. Managers need to ensure that conduct issues and staff grievances are dealt with promptly and effectively. This recommendation is ongoing with the Healthcare Trust.

The Panel perspective is the review has highlighted that the primary care and treatment of Mr YZ did not benefit from the wider picture available to the OH physicians working to support him as a member of staff in the same organisation, namely, the National Health Service; nor was it standard practice to reciprocate. This is a paradox that can only be resolved by NHS England issuing practice guidance that would provide clarity in the albeit unlikely event of a similar scenario in future. The family of Mr AB and Mr YZ have indicated that this, with the recommendations above, would meet their expectations for this review.

Therefore, it is recommended:

*That NHS England study the Domestic Homicide Review overview report into the death of Mr AB in Tower Hamlets in August 2015 to identify a policy and protocol for the sharing of information between NHS Occupational Health physicians and Primary Care Practices for the safety of patients and staff.*

[As this is a national recommendation, there is no requirement for a local action plan]

Bill Griffiths CBE BEM QPM

2 March 2018